Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY - PUBLIC

February 19, 2026

[redacted]
SHP V WILLISTOWN LLC
[redacted]

RE: ARBOR TERRACE WILLISTOWN
1713 WEST CHESTER PIKE
WEST CHESTER, PA, 19382
LICENSE/COC#: 14245

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/16/2025 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *ARBOR TERRACE WILLISTOWN* **License #**: *14245* **License Expiration**: *07/19/2026*

Address: *1713 WEST CHESTER PIKE, WEST CHESTER, PA 19382*

County: *CHESTER* **Region**: *SOUTHEAST*

Administrator

Name: [redacted] **Phone**: [redacted] **Email**: [redacted]

Legal Entity

Name: *SHP V WILLISTOWN LLC*

Address: [redacted]

Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

Type: *I-1* **Date**: *11/01/2021* **Issued By**: *West Whiteland Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *117* **Waking Staff**: *88*

Inspection Information

Type: *Partial* **Notice**: *Unannounced* **BHA Docket #**:

Reason: *Monitoring* **Exit Conference Date**: *12/16/2025*

Inspection Dates and Department Representative

12/16/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *104* **Residents Served**: *86*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory Care* **Capacity**: *35* **Residents Served**: *31*

Hospice

Current Residents: *11*

Number of Residents Who:

Receive Supplemental Security Income: *NA*

Are 60 Years of Age or Older: *85*

Diagnosed with Mental Illness: *NA*

Diagnosed with Intellectual Disability: *NA*

Have Mobility Need: *31*

Have Physical Disability: *NA*

Inspections / Reviews

12/16/2025 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/22/2026*

01/26/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *02/11/2026*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/31/2026*

Inspections / Reviews *(continued)*

02/03/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *02/11/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *02/09/2026*

02/19/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *02/11/2026*

Reviewer: [redacted] **Follow Up Type:** *Not Required*

16c - Written Incident Report

1. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On [redacted] at 8am, Resident [redacted] was administered an [redacted] that was prescribed for Resident [redacted]. The home did not submit an incident report to the Department until [redacted] at 6:19pm.

Repeat Violation [redacted]

Plan of Correction ***Accept [redacted] - 02/03/2026)***

Immediate Corrective Action:
Upon identification of the delayed reporting, the Executive Director reviewed the incident reporting requirements with leadership staff on 12/17/25. All staff will be re-educated by the Executive Director on policy and visual signage postage by 2/6/26.
Quality Improvement and Ongoing Compliance:
We have added signage outlining reportable incidents and the 24-hour reporting requirement and who to contact was developed and posted in multiple high-visibility staff areas, including medication rooms, nurses' stations, time clock areas, and staff offices by 1/13/26. This signage serves as an ongoing prompt for all employees to recognize and report incidents in a timely manner. Executive Director or designee starting 1/30 will monitor IR to determine which ones meet requirement for state reportable. This will be completed daily and daily ongoing to maintain compliance. Manager on duty on weekend reviewing the daily stand up logs for Incidents and notifying ED in timely manner. The Executive Director is responsible for ongoing compliance.
Evidence of Completion:
Photos of posted signage, incident review logs, and training documentation.

Licensee's Proposed Overall Completion Date: *02/06/2026*

Implemented ([redacted] 02/18/2026)

51 - Criminal Background Check

2. Requirements

2600.
51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Staff person A was hired on [redacted] to date no criminal background check has been completed as of [redacted].

Staff person B was hired on [redacted], while a criminal background was completed on [redacted]. Staff person B lives outside of Pennsylvania, and an FBI clearance has not completed as of [redacted].

Plan of Correction ***Accept [redacted] - 02/03/2026)***

Immediate Corrective Action:
Staff person B did have required background clearances. Documents were reviewed and verified by surveyor onsite,

51 - Criminal Background Check (continued)

please regard staff person B comment. Staff person A's required criminal background and FBI clearances were requested and were completed on 12/16/25.
Quality Improvement and Ongoing Compliance:
The onboarding process was reviewed by the Executive Director on 12/17/2025 with the Business Office Director. Monthly audits of all personnel files, including agency staff, will be completed by the Business Office Director starting 1/26/26 until 4/30/26. The Business Office Director is responsible for ongoing compliance.
Evidence of Completion:
Updated onboarding checklist, and audit logs.

Licensee's Proposed Overall Completion Date: *02/06/2026*

Implemented [redacted] 02/19/2026)

81b - Resident Personal Equipment

3. Requirements

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

A bedside mobility device, observed on the bed of resident [redacted] was not securely attached to the frame of the bed. Bedside mobility devices that slide under the mattress and are not securely attached to the structure of the bed can move and create entrapment zones not always present upon inspection. These types of devices are not permitted under any circumstance.

Repeat Violation: [redacted] et al.

Plan of Correction ***Accept [redacted] - 02/03/2026)***

Immediate Corrective Action:
The bedside mobility device for Resident [redacted] was removed on 1/24/26 by the Maintenance Director.

Quality Improvement and Ongoing Compliance:
The Executive Director will re-educate all staff by 02/6/26 on approved versus prohibited mobility devices and the requirement for leadership approval prior to use. Care Director(s) and Maintenance Director(s) will maintain a list of bed mobility devices. Beginning 2/3, the Maintenance Director or designee will inspect placement of the bed mobility devices monthly to ensure compliance with 2600.81b. Documentation will be maintained by the Maintenance Director and compliance will be reported quarterly to QI committee. Any unapproved equipment identified will be removed immediately. The Maintenance Director and Care Director(s) are responsible for ongoing compliance.
Evidence of Completion:
Staff education documentation and list of mobility devices

Licensee's Proposed Overall Completion Date: *02/06/2026*

Implemented [redacted] - 02/19/2026)

82b - Poisonous Material Storage

4. Requirements

2600.
82.b. Poisonous materials shall be stored separately from food, food preparation surfaces and dining surfaces.

Description of Violation

[redacted] *spray cleaner with manufacturer's label indicating "Keep out of reach of children. Wash hands thoroughly after handling, get medical advice/attention if you feel ill after use", was stored on the shelf above fresh produce. An additional spray bottle of this cleaner was observed next to the silverware on the server station.*

Plan of Correction ***Accept [redacted] - 02/03/2026)***

Immediate Corrective Action:
All cleaning products were immediately removed from food storage and service areas on 12/16/2025 and relocated to approved designed chemical storage area by the Dining Director.
Quality Improvement and Ongoing Compliance:
Kitchen and dining staff will be re-educated by 2/6/26 on proper storage of poisonous materials by the Executive Director. Starting on 1/26/26 there will be weekly audits for the next 4 weeks of food preparation and storage areas by the Dining director or designee.

Evidence of Completion:
Training sign-in sheets and audit logs.

Licensee's Proposed Overall Completion Date: *02/06/2026*

Implemented [redacted] 02/18/2026)

82c - Locking Poisonous Materials

5. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

Dial antibacterial soap, with a manufacture's label indicating "Contact poison control if swallowed", was unlocked, unattended, and accessible in the memory care kitchenette. Not all the residents of the home have been assessed capable of recognizing and using poisons safely.

Crest detoxifying toothpaste, with a manufacture's label indicating " If more than the normal amount to brush teeth is swallowed contact poison control ", was unlocked, unattended, and accessible in Resident [redacted] bedroom. Not all the residents of the home have been assessed capable of recognizing and using poisons safely, including Resident [redacted]

Secret deodorant, with a manufacture's label indicating " If ingested contact poison control", was unlocked, unattended, and accessible in Resident [redacted] bedroom. Not all the residents of the home have been assessed capable of recognizing and using poisons safely, including Resident [redacted]

82c - Locking Poisonous Materials (continued)

Repeat Violation[redacted]

Plan of Correction ***Accept*** [redacted] ***- 02/03/2026)***

Immediate Corrective Action:
All identified personal care and hygiene products were immediately secured and made inaccessible on 12/16/2025 by Care Director or designee. A community-wide sweep of resident rooms and memory care common areas were completed to confirm no additional unsecured items were present.
Quality Improvement and Ongoing Compliance:
Staff education on identifying and securing poisonous materials was reinforced by the Executive Director by 2/6/26. A two-tier audit process has been implemented: weekly audits beginning on 1/26/26 for 60 days by department leadership, followed by monthly audits beginning 4/1/2026 thereafter by care director or designee. Audit results will be reviewed during Quality Improvement meetings and repeat findings will result in immediate corrective coaching.
Evidence of Completion:
Audit logs, staff training documentation, and QI meeting minutes.

Licensee's Proposed Overall Completion Date: *02/06/2026*

Implemented [redacted] ***- 02/18/2026)***

88a - Surfaces

6. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On [redacted]*, two electrical cords were observed laying across the floor from bed to wall in Resident* [redacted] *bedroom, posing a tripping hazard.*

Plan of Correction ***Accept*** [redacted] ***- 01/26/2026)***

Immediate Corrective Action:
Electrical cords creating a tripping hazard were immediately repositioned and secured on 12/16/2025 by Maintenance Director.
Quality Improvement and Ongoing Compliance:
Room safety checks by maintenance director or designee will include cord management and trip hazard review during monthly inspections beginning January 2026. All staff will be educated by the Executive Director on regulation and examples of instances and items to look out for by 2/6/26. The Maintenance Director is responsible for ongoing compliance.
Evidence of Completion:
Staff training documentation and inspection checklists.

Licensee's Proposed Overall Completion Date: *02/06/2026*

Implemented ([redacted] ***- 02/18/2026)***

95 - Furniture and Equipment

7. Requirements

95 - Furniture and Equipment *(continued)*

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

On [redacted] a puddle of standing water was observed on the floor of the mechanical room, measuring approximately one foot by two foot with black and brown particles, appearing to be mold. Present in the puddle, a grey open trash receptacle located underneath two large insulated pipes was lain which appeared to be an effort to catch dripping water.

Plan of Correction ***Accept[redacted] - 02/03/2026)***

Immediate Corrective Action:
The standing water and debris in the mechanical room were addressed immediately on 12/16/2025 by the Maintenance Director. The area was cleaned, and a maintenance repair to address the source of the leak was completed on 1/13/26.
Quality Improvement and Ongoing Compliance:
Preventative maintenance rounds will include inspection of mechanical rooms weekly starting in January 2026 for the next four weeks then monthly thereafter. The audits will be completed by the Maintenance Director or designee. The Maintenance Director is responsible for ongoing compliance.
Evidence of Completion:
Work orders, photos, and maintenance logs.

Licensee's Proposed Overall Completion Date: *02/06/2026*

Implemented[redacted] - 02/18/2026)

100b - Removal Snow/Obstructions

8. Requirements

2600.
100.b. The home shall ensure that ice, snow and obstructions are removed from outside walkways, ramps, steps, recreational areas and exterior fire escapes.

Description of Violation

On [redacted] at approximately 9:40a, approximately three inches of accumulated snow was observed on the ground in the memory care courtyard. The National Oceanic and Atmospheric Administration (NOAA) reports that approximately 6.5 inches of snow fell in the area on [redacted]

Plan of Correction ***Accept[redacted] - 01/26/2026)***

Immediate Corrective Action:
Snow was removed from the memory care courtyard immediately following identification on 12/16/2025.
Quality Improvement and Ongoing Compliance:
The snow removal plan was reviewed by the Maintenance Director with the third-party vendor on 12/16/25. Exterior areas will be monitored daily during inclement weather by the department leadership team. The Executive Director will educate all staff on regulation by 2/6/26.
Evidence of Completion:
Snow removal logs and photo documentation as necessary.

Licensee's Proposed Overall Completion Date: *02/06/2026*

Implemented[redacted] - 02/18/2026)

100b - Removal Snow/Obstructions *(continued)*

101j7 - Lighting/Operable Lamp

9. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Resident [redacted] does not have access to a source of light that can be turned on/off at bedside.

Resident [redacted] does not have access to a source of light that can be turned on/off at bedside.

Plan of Correction ***Accept [redacted] - 02/03/2026)***

Immediate Corrective Action:
Non-functioning bedside lamps were repaired or replaced on 12/16/2025 and verified operational by the Maintenance Director or designee.
Quality Improvement and Ongoing Compliance:
Bedside lighting checks have been added to monthly room safety inspections to be completed by the Maintenance Director or designee beginning 1/26 weekly for the next 6 weeks. All staff will be re-educated by the Executive Director on resident(s) bedside requirements by 2/6/26. The Maintenance Director is responsible for ongoing compliance.
Evidence of Completion:
Inspection checklists and staff training documentation.

Licensee's Proposed Overall Completion Date: *02/06/2026*

Implemented [redacted] - 02/18/2026)

121a - Unobstructed Egress

10. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

On [redacted] at 9:54a, the keypad used to operate the doors was frozen and inoperable, and blocked egress from the home's memory care outdoor courtyard.

Plan of Correction ***Accept [redacted] - 01/26/2026)***

Immediate Corrective Action:
The frozen and inoperable keypad was addressed immediately on 12/16/2025 to restore safe egress.
Quality Improvement and Ongoing Compliance:
Keypads and egress points will be inspected by the Maintenance Director or designee daily during winter conditions. Outside keypad has had covered added to protect the buttons from freezing. All staff will be re-educated by the Executive Director on unobstructed egress by 2/6/26.
Evidence of Completion:

121a Unobstructed Egress (continued)

Inspection logs and staff training documentation.

Licensee's Proposed Overall Completion Date: *02/06/2026*

Implemented [redacted] - 02/18/2026)

182b - Prescription Medication

11. Requirements

2600.
182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:
4. A staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

Description of Violation

On [redacted] and [redacted] at 8am Staff person C administered medications to residents to include the following: [redacted] and [redacted]. Staff person C is not a staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of [redacted] and [redacted] prescription medications; [redacted] and [redacted] injections for insect bites or other allergies.

On [redacted] at 8pm Staff person D administered medications to residents to include the following: Melatonin tab 3mg. Staff person Dis not a staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of [redacted] and [redacted] prescription medications; [redacted] and [redacted] for insect bites or other allergies.

Plan of Correction ***Accept ([redacted] - 02/03/2026)***

mmediate Corrective Action:
Staff not medication administration trained were immediately removed from medication duties on 12/16/2025.
Quality Improvement and Ongoing Compliance:
Medication administration certification requirements reviewed by the Executive Director on 12/16/25. Staff all re certified by PA Train the Trainer by 2/6/26. Training records will be reviewed monthly by the Care Director or designee beginning 1/26/26 for next 6 months. The Care Director is responsible for ongoing compliance.
Evidence of Completion:
Training certificates and audit logs.

Licensee's Proposed Overall Completion Date: *02/06/2026*

Implemented [redacted] 02/18/2026)

186b - Medication Used by Resident

12. Requirements

2600.
186.b. Prescription medications shall be used only by the resident for whom the prescription was prescribed.

186b - Medication Used by Resident *(continued)*

Description of Violation

On [redacted] at 8am, Staff person E provided an [redacted] to resident [redacted] that was prescribed for Resident [redacted] Resident [redacted] self-administers medications. After inhaling the medication, resident [redacted] noticed that the label had another resident's name.

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Plan of Correction ***Accept [redacted] - 02/03/2026)***

The medication error was addressed immediately upon discovery on 12/9/2025.

Quality Improvement and Ongoing Compliance:
The Executive Director will re-educate medication administration procedures with all LPN and medication technician staff by 2/6/26. Residents who are assessed to safely self-administer medications will be reminded by the Care Director(s) to read the label and directions before taking the medication. When possible, the resident that self-administers their medication will be responsible for procuring the medication from their pharmacy. If staff handle medications for residents that self-administer, they will be reminded to check labeling for resident name before delivering the medication package to the resident. The Care Director(s) are responsible for ongoing compliance.
Evidence of Completion: Training documentation

Licensee's Proposed Overall Completion Date: *02/06/2026*

Implemented [redacted] - 02/18/2026)

187d - Follow Prescriber's Orders

13. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident [redacted] was administered [redacted] on [redacted] at 8:30am, however this medication was discontinued on [redacted].

Repeat Violation [redacted] et al.

Plan of Correction ***Accept [redacted] - 02/03/2026)***

Immediate Corrective Action:
Medication orders were reviewed immediately on 12/9/25, and discontinued medications were removed from medication administration records. Nursing leadership verified current orders against prescriber documentation to ensure accuracy.
Quality Improvement and Ongoing Compliance:
Care director(s) and designees will be trained by 2/6/26 to review and approve orders in ALIS to monitor pharmacy order page for changes, process changes and for discontinued medications, remove medication from the cart. Additionally, if community staff discontinue the order in ALIS (EHR) they will fax a copy of the discontinued order to the pharmacy alerting them of the order change.. Any discrepancies identified will be corrected immediately and reviewed in Quality Improvement meetings.
All medication technicians will have a med pass observation completed by a licensed nurse by 2/6/26. The Care

187d Follow Prescriber's Orders (continued)

Director(s) will monitor medication administration reports daily starting 1/26/26 and will complete daily monitoring ongoing to maintain compliance.
Evidence of Completion:
MAR audits, updated medication orders, training sign in sheets, and QI documentation.

Licensee's Proposed Overall Completion Date: *02/06/2026*

Implemented [redacted] 02/18/2026)

233c - Key-Locking Devices

14. Requirements

2600.
233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

The directions for operating the home's locking mechanism are not conspicuously posted near the door in the dining room leading the courtyard in the Secure Dementia Care Unit (SDCU).

Repeat Violation [redacted]

Plan of Correction ***Accept [redacted] - 02/03/2026)***

Immediate Corrective Action:
Required operating instructions were posted near the affected door on 12/16/2025. Visibility and accuracy of the signage were verified by the DHS surveyor.
Quality Improvement and Ongoing Compliance:
The Executive Director will re educate all staff on key locking device operating instructions by 2/6/26. All secured doors will be audited beginning on 1/26 weekly for 60 days and monthly thereafter by the Maintenance Director or designee to ensure instructions remain conspicuous, accurate, and intact. Findings will be documented and reviewed by Executive Director or designee during QI meetings. QI meeting scheduled for 2/3. Any missing or damaged signage will be replaced immediately.
Evidence of Completion:
Photo documentation, audit logs, and staffing training documentation.

Licensee's Proposed Overall Completion Date: *02/06/2026*

Implemented [redacted] - 02/18/2026)